

§ 417.432

(7) The HMO or CMP promptly notifies the beneficiary of the effective month of his or her enrollment as a Medicare enrollee, when it receives that information from CMS.

(8) If the HMO or CMP accepts applications while it is enrolled to capacity, its procedures ensure that vacancies are filled in chronological order by date of application of beneficiaries who are still eligible to enroll, unless that would result in failure to comply with any of the qualifying conditions set forth in § 417.413.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 76 FR 21560, Apr. 15, 2011]

§ 417.432 Conversion of enrollment.

(a) *Basic rule.* An HMO or CMP must accept as a Medicare enrollee any individual who is enrolled in the HMO or CMP for the month immediately before the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(b) *Effective date of conversion.* Unless the individual chooses to disenroll from the HMO or CMP the individual's conversion to a Medicare enrollee is effective the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(c) *Prohibition against disenrollment.* An HMO or CMP may not disenroll an individual who is converting under the provisions of paragraph (a) of this section unless one of the conditions specified in § 417.460 is met.

(d) *Application form.* The individual who is converting must complete an application form or another CMS-approved election mechanism as described in § 417.430(a).

(e) *Expedited submittal of information to CMS.* The HMO or CMP must notify CMS, within the following time frames, of the enrollee's authorization for disclosure and exchange of information and the information necessary for CMS to include the enrollee in its records as a Medicare enrollee of the HMO or CMP:

(1) At least 30, but no earlier than 90, days before the enrollee—

(i) Attains age 65; or

(ii) Reaches his or her 25th month of entitlement to social security disability benefits under title II of the Act

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or railroad retirement disability benefits under section 7(d) of the Railroad Retirement Act of 1974.

(2) Within 30 days after the enrollee initiates a course of renal dialysis, or on or before the day he or she enters a hospital in anticipation of a kidney transplant.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46570, Sept. 13, 1991; 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 77 FR 22166, Apr. 12, 2012]

§ 417.434 Reenrollment.

If an HMO or CMP requires periodic reenrollment, it must reenroll Medicare enrollees unless there is a basis for disenrollment as set forth in § 417.460.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.436 Rules for enrollees.

(a) *Maintaining rules.* An HMO or CMP must maintain written rules that deal with, but need not be limited to the following:

(1) All benefits provided under the contract, as described in § 417.440.

(2) How and where to obtain services from or through the HMO or CMP.

(3) The restrictions on coverage for services furnished from sources outside a risk HMO or CMP, other than emergency services and urgently needed services (as defined in § 417.401).

(4) The obligation of the HMO or CMP to assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services as required by § 417.414(c).

(5) Any services other than the emergency or urgently needed services that the HMO or CMP chooses to provide as permitted by this part, from sources outside the HMO or CMP. A cost HMO or CMP must disclose that the enrollee may receive services through any Medicare providers and suppliers.

(6) Premium information, including the amount (or if the amount cannot be included, the telephone number of the source from which this information may be obtained) and the procedures for paying premiums and other charges for which enrollees may be liable.

(7) Grievance and appeal procedures.

(8) Disenrollment rights.

(9) The obligation of an enrollee who is leaving the HMO's or CMP's geographic area for more than 90 days to notify the HMO or CMP of the move or extended absence and the HMO's or CMP's policies concerning retention of enrollees who leave the geographic area for more than 90 days, as described in §417.460(a)(2).

(10) The expiration date of the Medicare contract with CMS and notice that both CMS and the HMO or CMP are authorized by law to terminate or refuse to renew the contract, and that termination or nonrenewal of the contract may result in termination of the individual's enrollment in the HMO or CMP.

(11) Advance directives as specified in paragraph (d) of this section.

(12) Any other matters that CMS may prescribe.

(b) *Availability of rules.* The HMO or CMP must furnish a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter.

(c) *Changes in rules.* If an HMO or CMP changes its rules, it must submit the changes to CMS in accordance with §417.428(a)(3), and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

(d) *Advance directives.* (1) An HMO or CMP must maintain written policies and procedures concerning advance directives, as defined in §489.100 of this chapter, with respect to all adult individuals receiving medical care by or through the HMO or CMP and are required to:

(i) Provide written information to those individuals concerning—

(A) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Such information must reflect changes

in State law as soon as possible, but no later than 90 days after the effective date of the State law; and

(B) The HMO's or CMP's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the HMO or CMP cannot implement an advance directive as a matter of conscience. At a minimum, this statement should:

(1) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(2) Identify the state legal authority permitting such objection; and

(3) Describe the range of medical conditions or procedures affected by the conscience objection.

(ii) Provide the information specified in paragraphs (d)(1)(i) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the HMO or CMP may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The HMO or CMP is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(iii) Document in the individual's medical record whether or not the individual has executed an advance directive;

(iv) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(v) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives;

(vi) Provide for education of staff concerning its policies and procedures on advance directives; and

(vii) Provide for community education regarding advance directives that may include material required in paragraph (d)(1)(i)(A) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the HMO or CMP. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An HMO or CMP must be able to document its community education efforts.

(2) The HMO or CMP—(i) Is not required to provide care that conflicts with an advance directive.

(ii) Is not required to implement an advance directive if, as a matter of conscience, the HMO or CMP cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object.

(3) The HMO or CMP must inform individuals that complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency.

[58 FR 38072, July 15, 1993, as amended at 59 FR 49843, Sept. 30, 1994; 60 FR 33292, June 27, 1995]

§ 417.440 Entitlement to health care services from an HMO or CMP.

(a) *Basic rules.* (1) Subject to the conditions and limitations set forth in this subpart, a Medicare enrollee of an HMO or CMP is entitled to receive health care services and supplies directly from, or through arrangements made by, the HMO or CMP as specified in this section and §§ 417.442–417.446.

(2) A Medicare enrollee is also entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the HMO or CMP if those services are—

(i) Emergency services or urgently needed services as defined § 417.401;

(ii) Services denied by the HMO or CMP and found (upon appeal under subpart Q of this part) to be services the enrollee was entitled to have furnished by the HMO or CMP.

(b) *Scope of services*—(1) *Part A and Part B services.* Except as specified in paragraphs (c), (d), and (e) of this section, a Medicare enrollee is entitled to receive from an HMO or CMP all the Medicare-covered services that are available to individuals residing in the HMO's or CMP's geographic area, as follows:

(i) Medicare Part A and Part B services if the enrollee is entitled to benefits under both programs.

(ii) Medicare Part B services if the enrollee is entitled only under that program.

(2) *Supplemental services elected by an enrollee.* (i) Except as provided under paragraph (b)(2)(ii) of this section, a Medicare enrollee of an HMO or CMP may elect to pay for optional services that are offered by the HMO or CMP in addition to the covered Part A and Part B services.

(ii) An HMO or CMP may elect to provide qualified prescription drug coverage (as defined at § 423.104 of this chapter) as an optional supplemental service in accordance with the applicable requirements under part 423 of this chapter, including § 423.104(f)(4) of this chapter.

(iii) The HMO or CMP may not set health status standards for those enrollees whom it accepts for these optional supplemental services.

(3) *Supplemental services imposed by a risk HMO or CMP.* (i) Subject to CMS's approval, a risk HMO or CMP may require Medicare enrollees to accept and pay for services in addition to those covered by Medicare. (ii) If the HMO or CMP elects this option, it must impose the requirement on all Medicare enrollees, without regard to health status. (iii) CMS approves supplemental benefits of this type if CMS determines that imposition of the requirements will not discourage other Medicare beneficiaries from enrolling in the risk HMO or CMP.

(4) *Additional benefits from risk HMOs or CMPs required by statute.* Subject to